TESTIMONY BEFORE THE SPECIAL COMMISSION ON THE HEALTH CARE PAYMENT SYSTEM

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Like most of the people in this room, I suspect, I am proud and pleased, but also humbled and nervous about the leadership our Commonwealth has taken in providing health care for all of its citizens. We've got to make the Massachusetts plan work. We're all determined to make it work.

But our grand experiment is in big trouble: it costs more than we can afford. That was true before the economic collapse. It is even more so now, both because of reduced state revenues and because as they lose their jobs more and more of our citizens will not be able to afford health insurance.

It is clear that we will not be able to provide health care for everyone unless we dramatically reduce costs. Not just decrease the annual increases, not just "bend the curve", but actually **reduce** health care costs.

A number of proposals are before you on how to do that. Many focus on changing our payment system away from paying for individual services to paying for more comprehensive care: "bundled" payments, integrated and coordinated team-based care, medical homes, etc.

I come before you to support those efforts, because, in addition to being the most effective way to get costs under control, payment for comprehensive, integrated, team-based care is also what we need to improve quality and safety. Poor quality is the major cause of our high costs – and we can do something about it.

We have major quality and safety problems in health care:

- **Waste**. Health care is incredibly wasteful. Paul O'Neill, former Secretary of the Treasury and CEO of Alcoa estimates that waste accounts for 50% of health care expenses. That may be high, but everyone has seen the inefficiencies that are common in health care: missing records, lost x-rays and lab tests, waiting and congestion in the emergency room, and so forth. No other industry could survive with such waste.
- **Overuse**, receiving treatments and tests that you don't need, is endemic. Studies show at least 20% of care is unnecessary. For example, 43% of children received antibiotics for a sore throat without even getting a strep test. Hundreds get unnecessary MRIs.
- **Underuse**, the failure to get treatment that will help you, is also common – and costly in terms of increased later health costs. Screening tests for prevention, vaccinations, and early treatment of complications of diseases such as diabetes

- **Medical errors**: thousands of patients are injured by preventable complications and mistakes. One condition alone, bloodstream infection related to central lines, takes 20,000 lives and costs $1.5 billion a year in our country.
- **Care of the chronically ill**. Although they represent only 10% of the population, patients with severe chronic disease consume 75% of all health expenditures. Most do not get the high quality, coordinated care we know how to give. If they did, their lives would be improved and their costs could be cut in half.

If we address these quality and safety problems, putting into practice what we already know, we will not only greatly improve the health and welfare of our citizens, we will reduce health care cost substantially -- by at least 25%. Putting it another way, **unless** we deal with the quality and safety problems, we will not be able to cut costs.

How do we do that? Many of us have been disappointed by our progress in improving quality and safety. The IOM report came out 9 years ago, but it is hard to prove that care is much safer.

But we've learned a lot. We've learned that it's not enough to just require that a hospital report mistakes, or put in a new practice or guidelines. Change in practice only happens when all of the caregivers – doctors, nurses, pharmacists, social workers, and others, **work together in teams**.

You may have seen the recent report of a dramatic reduction in surgical mortality by use of a simple checklist. Well, it isn't the checklist that makes the difference, it's the need to work as a team to use the checklist that makes the difference. It's the same with the dramatic reductions we've seen in infections – total elimination of central line infections in over 60 hospitals in Michigan. How did they do it? By working together in interprofessional teams.

And that's also how we've made dramatic improvements in the care of chronic diseases – such as the outstanding results right here at the Cambridge Health Alliance in the management of patients with asthma and diabetes: by providing comprehensive, coordinated care by doctors, nurses, pharmacists, physician assistants and others working together and with the community, in teams.

How do we promote integrated, coordinated care by interprofessional teams? By paying for it. Our current fee-for-service payment system works against practicing in teams. It doesn't pay, or it pays poorly, for nonphysician services, for counseling, for coordination, for making things work. In fact, it makes things worse:

Our fee-for-service system:

- **Encourages overuse** - both the doctor and the patient have every incentive to do everything that might possibly help. Why not get an MRI for your headache or twisted ankle?

- **Devalues primary, integrated, coordinated care** by paying much more for specialist care. Big surprise: we have a shortage of primary care physicians

- **Encourages waste**. There is no reason to economize. It is estimated that 20% of studies in hospitals are repeated because they can't find the results.

- **Penalizes good care**. Classic example: Asthma. You teach the patient to care for themselves, monitor their breathing, treat themselves early. Result: you dramatically reduce office visits, ER visits, and admissions to the hospital (by 90%) and everyone loses money!

- **Rewards poor care**. Hospitals charge for treatment of complications and pay for extra days due to HAI and other mishaps

Fee-for service is the **anti-team**.

To improve quality and safety, we have to change the way we practice medicine. We have to move from an individualistic service-based approach to comprehensive team-based care. It doesn't make any difference whether you call it a medical home, or a neighborhood health center, or even a multispecialty group, it's whether they provide truly integrated, coordinated, interprofessional team care that counts.

We need to do three things:

1. Pay for <u>care</u>, not for individual <u>services</u>

- Pay for **coordinated** care which is continuous over time and place – in and out of the hospital, the home, the nursing home – and meets the patient's needs at the right time and in the right environment. Not just when they decide to come to the office with a problem.
- We need to quit paying for uncoordinated, episodic single-specialty care in 10 different places at 10 different times
- We have to stop paying fee-for-service

2. We need to pay groups, not individuals

- a multispecialty group, a medical home, a clinic, a team, an HMO – any or all of these – we need to experiment
- We need to do a lot of work figuring out how to do this – fortunately it has begun
- But, it's clear what we need: a system where all providers – primary care physicians and specialists, nurses, therapists, social workers, technicians – all work together to figure out how best to meet all of the patient's needs - interprofessional teams

The major cause of high costs is poor quality, unsafe care. We cannot improve quality and safety unless we change what we pay for – not **how** we pay for care, whether through

public or private payers, but **what** we pay for. We need to pay for integrated, coordinated, interprofessional team care.